UnitedHealthcare: Vanderbilt University 2020-99-2

Coverage Period: 07/01/2020 - 08/11/2021 Coverage for: Student/Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.uhcsr.com/vanderbilt or call 1-844-210-0545. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance (coins)</u>, <u>copayment (copay)</u>, <u>deductible (ded)</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-844-210-0545 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Select Providers \$250 (Person)  Preferred Providers \$250 (Person)  Out of Network \$500 (Person)	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , Pediatric Dental, Pediatric Vision and categories that specify <u>ded</u> does not apply.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes. Pediatric Dental \$500 and Prescription Drugs \$100. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Preferred Providers & In-Network Providers \$5,000 (Person) Preferred Providers & In-Network Providers \$10,000 (Family)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.uhcsr.com/vanderbilt or call 1-844-210-0545 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before you get services</u>.</u>
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

Common Medical Event	Services You May Need	What You Will Pay				
		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 Copay per visit ded does not apply	\$25 Copay per visit ded does not apply	40% <u>Coins</u>	May not apply when related to surgery o	
	<u>Specialist</u> visit	\$25 Copay per visit ded does not apply	\$25 Copay per visit ded does not apply	40% <u>Coins</u>	Physiotherapy.	
	Preventive care/screening/immunization	No Charge	No Charge	40% <u>Coins</u>	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a toot	Diagnostic test (x-ray, blood work)	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you have a test	Imaging (CT/PET scans, MRIs)	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you need drugs to treat your illness or condition	Tier 1 - Your Lowest-Cost Option	\$15 <u>Copay</u> per prescription Tier 1	\$15 <u>Copay</u> per prescription Tier 1	0% <u>Coins</u>	Select Providers: up to a 30 day supply per prescription  Preferred Providers: up to a 30 day supply per prescription	
More information about prescription drug coverage is available at	Tier 2 - Your Midrange-Cost Option	\$50 <u>Copay</u> per prescription Tier 2	\$50 <u>Copay</u> per prescription Tier 2	0% <u>Coins</u>	You may need to obtain certain <u>specialty</u> <u>drugs</u> from a pharmacy designated by us. Select: \$100 <u>Ded</u> (per Policy Year) does not apply to Policy <u>Ded</u> . Mail order	
www.uhcsr.com/pdl	Tier 3 - Your Highest-Cost Option	\$75 Copay per	\$75 Copay per	Not Covered	Prescription Drugs through Express Scripts network pharmacy at 2 times the	

	Services You May Need	What You Will Pay				
Common Medical Event		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
		prescription Tier 3	prescription Tier 3		retail <u>Copay</u> up to a 90-day supply. Preferred: \$100 <u>Ded</u> (per Policy Year)	
	Tier 4 - Additional High-Cost Option  Not Covered  Not Covered		does not apply to Policy <u>Ded</u> . Mail order <u>Prescription Drugs</u> through Express Scripts network pharmacy at 2 times the retail <u>Copay</u> up to a 90-day supply. Out: No Benefits			
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	none	
surgery	Physician/surgeon fees	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you need immediate medical attention	Emergency room care	10% <u>Coins</u> \$100 <u>Copay</u> per visit <u>ded</u> does not apply	10% Coins \$100 Copay per visit ded does not apply	10% <u>Coins</u> \$100 <u>Copay</u> per visit <u>ded</u> does not apply	May be limited to use of emergency room and supplies. The Copay will be waived if admitted to the Hospital.	
	Emergency medical transportation	No Charge	No Charge	No Charge	none	
	<u>Urgent care</u>	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	May be limited to facility fees.	
If you have a hospital	Facility fee (e.g., hospital room)	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	none	
stay	Physician/surgeon fees	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$25 <u>Copay</u> per visit <u>ded</u> does not apply Other: 10% <u>Coins</u>	Office Visits: \$25 <u>Copay</u> per visit <u>ded</u> does not apply Other: 20% <u>Coins</u>	Office Visits: 40% Coins Other: 40% Coins	none	
	Inpatient services	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	none	
	Office visits	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery professional services	10% <u>Coins</u>	20% <u>Coins</u>	40% Coins	services when provided by a preferred provider. Depending on the type of services, a copayment, coinsurance, or	

	Services You May Need	What You Will Pay				
Common Medical Event		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
					deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	10% <u>Coins</u>	20% Coins	40% <u>Coins</u>	none	
	Home health care	20% Coins	20% <u>Coins</u>	20% <u>Coins</u>	none	
If you need help	Rehabilitation services	10% Coins	20% Coins	40% <u>Coins</u>	none	
recovering or have	Habilitation services	10% Coins	20% Coins	40% <u>Coins</u>	none	
other special health	Skilled nursing care	10% Coins	20% <u>Coins</u>	40% <u>Coins</u>	none	
needs	Durable medical equipment	20% <u>Coins</u>	20% <u>Coins</u>	20% <u>Coins</u>	none	
	Hospice services	10% <u>Coins</u>	20% <u>Coins</u>	40% <u>Coins</u>	none	
If your child needs dental or eye care	Children's eye exam	See your plan's Pediatric Vision Benefit Details	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins; ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	
	Children's glasses	See your plan's Pediatric Vision Benefit Details	Lens: \$40 Copay; ded does not apply Frames: Tiered Copays from no charge to 40% based on retail cost. ded does not apply	50% <u>Coins; ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	
	Children's dental check-up	See your plan's Pediatric	50% <u>Coins</u>	50% <u>Coins</u>	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*	

Common Medical Event	Services You May Need	What You Will Pay			
		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Dental Benefit Details			

# **Excluded Services & Other Covered Services:**

# Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

Bariatric surgery

- Cosmetic surgery except as specifically provided in the Policy
- Dental care (Adult) except as specifically provided in the Policy

- Hearing aids except as specifically provided in the Policy
- Infertility treatment

• Long-term care

- Routine eye care (Adult) except as specifically provided in the Policy
- Weight loss programs

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Acupuncture

Chiropractic care

Non-emergency care when traveling outside the U.S.

Private-duty nursing

Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Tennessee Department of Commerce & Insurance at 1-800-342-4029 or visit http://www.tn.gov/commerce. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Tennessee Department of Commerce & Insurance at 1-800-342-4029 or visit http://www.tn.gov/commerce.

# Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

# Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

# **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-260-2723.

————To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.—————

# **About these Coverage Examples:**



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 D (a year of routine in-network ca controlled condition)	re of a well-	Mia's Simple Fracture (in-network emergency room visit and follow up care)		
■ The <u>plan's</u> overall <u>deductible</u> ■ <u>Specialist coinsurance</u> ■ Hospital (facility) <u>coinsurance</u> ■ Other <u>coinsurance</u>	\$250 20% 20% 20%	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist coinsurance</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$250 20% 20% 20%	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist coinsurance</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$250 20% 20% 20%	
This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)		This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)		This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services(physical therapy)		
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900	
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:		
Cost Sharing		Cost Sharing		Cost Sharing		
Deductibles	\$250	Deductibles \$250		Deductibles	\$250	
Copayments	\$20	Copayments	\$700	Copayments	\$0	
Coinsurance	\$2,500	Coinsurance	\$400	Coinsurance	\$200	
		What isn't covered		What isn't covered		
What isn't covered						
What isn't covered  Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0	

# NON-DISCRIMINATION NOTICE

UnitedHealthcare **Student**Resources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC\_Civil\_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>

Complaint forms are available at <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.

**Phone:** Toll-free **1-800-368-1019**, **800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

# LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

# English

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

#### Albanian

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

#### Amharic

የቋንቋ አርዳታ እንልማሎኖች በነጻ ይነኛነት። አባኪዎ ወደ 1-866-260-2723 ይደውነት።

# Arabic

تُتُوفِر أَكَ خدمات المساعدة اللّغوية مجانًا. اتصل على الرقم 2723-260-866-1.

### Armenian

Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ։ Խնդրում ենք զանգահարել 1-866-260-2723 համարով։

### Bantu- Kirundi

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

### Bisayan- Visayan (Cebuano)

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

# Bengali- Bangala

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দুয়া করে 1-866-260-2723-তে কল করুন।

### Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အစမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ် ပါ။

# Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។

សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

# Cherokee

\$\text{SQL} OOLOS\LAST \text{DOLOS\LAST} \text{NIGGOOD D4GOT. FGGO Dh \text{ObWOS\LAST} 1-866-260-2723.

# Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

# Choctaw

Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla hochi apela hinla. I paya 1-866-260-2723.

# Cushite- Oromo

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

# Dutch

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

SR LAP 64 (6-18)

#### French

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

### French Creole- Haitian Creole

Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

### German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

### Greek

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

### Guiarati

ભાષા સહ્યય સેવાઓ તમારા માટે નિશુલ્ક ઉપલબ્ધ છે. કુપા કરીને 1-866-260-2723 પર ક્રેલ કરો.

### Hawaiia

Kōkua manuahi ma kāu 'ōlelo i loa'a 'ia. E kelepona i ka helu 1-866-260-2723.

### Hindi

आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

### Hmong

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

#### Tho

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kp∞ 1-866-260-2723.

### Ilocano

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

### Indonesian

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

### Italian

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

# Japanese

無料の言語支援サービスをご利用いただけます。 1-866-260-2723 までお電話ください。

# Karet

ດຊື່ຄົວກ່ອນຄາເສດກິເຊບເຊົາສຳລາວວັດກາດວຽ້ອງຊົສເບຼາລາຊີ(ຕໍ່ເປື)ຊຸຊີເປັນ, ອ້ວມຊາເອົາເບຼີເລດຊີເລດີ 1-866-260-2723ຕາກຸກັ.

# Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

# Kru- Bass

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

# Kurdish Sorani

خۇمەتكەكى يارمەتنى زمانى بەخۋر ايى بۇ ئۆ دايىن دەكرىن. ئاكليە ئەلەقۇن باكە بۇ ئاماردى 2723-266-186.

# Laotian

ມືບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທໍ່ານ. ກະລຸນາໂທຫາເບີ I-866-260-2723.

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### Marathi

भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

### Marshallese

Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjelok wōṇāān. Jouj im kallok 1-866-260-2723.

# Micronesian-Pohnpeian

Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

# Navajo

Saad bee áka'e'eyeed bee áka'nida'wo'ígií t'áá jiík'eh bee nich'i' bee ná'ahoot'i'. T'áá shoodi kohjj' 1-866-260-2723 hodíilnih.

# Nepali

भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नृहोस्।

### Nilotic-Dinka

Kāk ē kuny ajuser ē thok atō tīnē yīn abac tē cīn wēu yeke thiēēc. Yīn col 1-866-260-2723.

# Norwegian

Du kan få gratis språkhjelp. Ring 1-866-260-2723.

### Pennsylvania Dutch

Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

# Persian-Farsi

خدمات امداد زباتي به طور رايگان در اختيار شما مي بشد. لطفاً با شماره 2723-1866-1 تماس مگيريد.

#### Polich

Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

### Portuguese

Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

# Punjabi

ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

# Romanian

Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

# Russian

Языковые услуги предоставляются вам бесплатно. Звоните по телефоту 1-866-260-2723.

# Samoan- Fa'asamoa

O loo maua fesoasoani mo gagana mo oe ma e le totogia. Faamolemole telefoni le 1-866-260-2723.

# Serbo-Croatian

Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

# Somali

Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

# Spanisl

Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

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# Sudanic- Fulfulde

B woodi walliinde dow wolde caahu ngam maada. Noodu 1-866-260-2723.

### Swahili

Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

# Syriac- Assyrian

چەدەلەتلەت دەندەقە مايىدە ئەرىكىدە ئەرىكىدە بەرىلىدىدى . مىرىدەندە . مەنى خارجىدىدە 2723-560-1861.

### Tagalog

Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

### Telugu

లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

### Thai

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จา ยแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข

# 1-866-260-2733

Tongan- Fakatonga 'Oku 'i ai pē 'a e sēvesi ki he lea' ke tokoni kiate koe pea 'oku 'atā ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he 1-866-260-2723.

# Trukese (Chuukese)

En mei tengeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

### Turkish

Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

### Harainia

Послуги перекладу падаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

# Urdu

زبان کے حوالے سے معارفتی خدمات آپ کے لیے بلامعارسہ دستباب ہیں۔ ہر ء مہرمتی 2723-866-1961 پر کان کریں۔

# Vietnamese

Dịch vụ hỗ trợ ngôn ngữ, miễn phi, dành cho quý vị. Xin vui lỏng gọi 1-866-260-2723.

# Yiddish

שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רפט 1-866-260-2723.

# Vorubs

Isệ tránlówó èdè ti ở jệ ôfé, wà fún ở. Pe 1-866-260-2723.

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